TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fort Duncan Medical Center

Respondent Name
TPS Joint Self INS Funds

MFDR Tracking Number
M4-16-0456-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
October 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Fort Duncan Medical Center to audit their Workers Compensation claims. We have found in this audit you have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

Amount in Dispute: $110.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. The code in dispute is listed as status indictor X, which per the CMS OPPS STVX-packaged service is packaged into the payment for the service(s) and no separate payment is made for the STVX-packaged service."

Response Submitted by: Injury Management Organization, Inc, 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2015	73610	$110.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 774 – CMS OPPS STVX – packaged service is packaged into the payment for the service(s) with status indicator S,T,V or X and no separate payment is made for the STVX packaged service
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 222 – Charge exceeds fee schedule allowance
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. The insurance carrier denied disputed services with claim adjustment reason code 774 – "CMS OPPS STVX – packaged service is packaged into the payment for the service(s) with status indicator S,T,V or X and no separate payment is made for the STVX packaged service." 28 Texas Administrative Code §134.403 (d) requires that,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   Review of the submitted information finds the services in question are related to Outpatient Hospital Services. The applicable Medicare payment policy is discussed below.

2. 28 Texas Administrative Code 134.403 (f) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 200 percent; unless
   > > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
   > >
   > > (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

The submitted medical claim did not include a separate request for implantable reimbursement. The services in dispute found on the DWC060 will be reviewed as follows;

- Procedure code 73610 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

3. The total allowable reimbursement for the services in dispute is $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 7, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.